Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675630	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2024
NAME OF PROVIDER OR SUPPLIER: Gulf Shores Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1301 S Terrell St Falfurrias, TX 78355	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on interviews and record review, the facility failed ensure residents were free of any significant medication errors for 1 of 8 residents (Resident #8) reviewed for significant medication errors. The facility failed to ensure that RN A administered Resident #8's Tresiba Flex Touch Solution Pen Injector on 8 of 9 opportunities from 11/1/24 to 11/30/24. This failure could place residents at risk of a decline in condition or hospitalization . The findings included: Record review of Resident #8's admission record reflected a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #8 ' s diagnoses included type 2 diabetes mellitus with hyperglycemia (persistently high blood sugar), type 2 diabetes mellitus with diabetic polyneuropathy (nerve damage caused by persistently high blood sugar) and cognitive communication deficit. Record review of Resident #8's quarterly MDS dated [DATE] reflected a BIMS of 8 which indicated moderate cognitive impairment. Record review of Resident #8's order summary report reflected the following orders: Check blood sugar levels via accucheck one time a day related to type 2 diabetes mellitus with hyperglycemia ordered on 7/9/24. Tresiba FlexTouch Subcutaneous Solution Pen Injector 100 units/ml (Insulin Degludec) Inject 62 units subcutaneously one time a day for diabetes ordered on 11/1/24. Record review of Resident #8's November 2024 MAR reflected the following: An order for Tresiba FlexTouch Subcutaneous Solution Pen Injector 100 units/ml (Insulin Degludec) Inject 62 units subcutaneously one time a day for diabetes at 6:00am (There were no hold parameters). Ordered on 11/1/24 at 3:51pm. This medication was held by RN A on 11/3/24 (BS 108), 11/10/24 (BS 97), 11/11/24 (BS 84), 11/17/24 (BS 81), 11/18/24 (BS 101), 11/24/24 (BS 83), 11/25/24 (BS 91), and 11/28/24 (BS 106) which was 8 of 9 opportunities that RN A had to administer the medication. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Attempts were made to contact RN A for interview on 12/3/24 at 3:33pm, 12/4/24 at 9:15am and 12:39pm by the state surveyor and on 12/04/24 at 09:43am, 12:36pm, and 12:37pm, by the DON with no success. In an interview on 12/4/24 at12:15pm the DON stated he did not know why the Tresiba was held since there were no hold orders. The DON stated it was important to follow physician orders for the Tresiba administration to make sure Resident #8's sugar did not go higher, the medication had the desired effect, and the resident did not have any undesired consequences. The DON stated he and the ADON were responsible for making sure that orders made sense and were followed. The DON stated if a medication was held, the physician should have been notified by telephone at that time, and it was supposed to be documented in the progress notes right away. The DON stated the last in-service on medication administration was in October and nurses were checked off on medication administration during orientation. The DON stated every morning they would pull an orders report that would show all of the new orders and any orders that were placed on hold, but they did not have a report to tell them when medications were not given. The DON stated he did not recall seeing that there was a pattern with Resident #8's Tresiba being held. The DON stated information regarding medications, treatments, etc. were put into the 24-hour report to pass along to the next shift, but he did not recall hearing anything about Resident #8 not getting her Tresiba during morning meetings. In an interview on 12/4/24 at 2:43pm the MD stated he was not aware of Resident #8's Tresiba being held and he would have expected to have been notified when it was held. The MD stated if he had been notified that the medication was not given, he would have asked the nurse why it was held and provided clarification of his order. The MD stated if medications were not given when they were supposed to be, it could cause the resident to have complications. The MD stated that if he was not notified of medication issues, he would not know what was going on with the resident and would not be able to provide effective care and treatment for the residents. The MD stated he would talk with the DON and the nurse to find out why the medication was not given and why he was not notified. Record review of the facility ' s Medication Administration Policy dated 4/1/19 and reviewed 7/8/24 reflected in part: Medications are administered in a safe and timely manner, and as prescribed. 2. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident ' s attending physician or the facility ' s medical director to discuss the concerns.